WellCare
Beyond Healthcare. A Better You.

NC Medicaid and NC Health Choice
Pharmacy Prior Approval Request for Aduhelm™

Beneficiary Information

01. Beneficiary Last Name: _____ 02. First Name: _____
03. Beneficiary ID #: _____ 04. Beneficiary Date of Birth: _____05. Beneficiary Gender: ___

Prescriber Information

06. Prescribing Provider NPI #: _____
07. Requester Contact Information:
Name: _____ Phone #: _____ Ext. ____

Drug Information

08. Drug Name: _____ 09. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days):
☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days

Clinical Information

01. Does the beneficiary have mild cognitive impairment due to Alzheimer's disease or Alzheimer's dementia?
☐ **Yes** ☐ **No**
02. Has the beneficiary received all of the tests listed below?
- Clinical Dementia Rating (CDR) with a global score of 0.5? ☐ **Yes** ☐ **No**
- Objective evidence of cognitive impairment at screening? ☐ **Yes** ☐ **No**
- Mini-Mental Status Exam (MMSE) with a score between 24 and 30 (inclusive) OR equivalent tool indicating MCI or mild dementia (note: range of scores may be adjusted based on educational status of patient)? ☐ **Yes** ☐ **No**
- Positron Emission Tomography (PET) scan showing positive for amyloid beta plaque OR Cerebrospinal Fluid Test (collected via lumbar puncture) showing positive for amyloid? ☐ **Yes** ☐ **No**

03. Is the beneficiary age 50 or older? ☐ **Yes** ☐ **No**
04. Has the beneficiary undergone testing to rule out reversible causes of dementia? ☐ **Yes** ☐ **No**
05. Has the beneficiary had an assessment that included a review of current medications as a cause of intellectual decline? ☐ **Yes** ☐ **No**
06. Has the beneficiary had a brain MRI within the past 12 months prior to beginning treatment? ☐ **Yes** ☐ **No**
07. Has the prescriber assessed and documented baseline disease severity utilizing an objective measure/tool?
☐ **Yes** ☐ **No**
08. Does the beneficiary have a history or increased risk of amyloid-related imaging abnormalities-edema (ARIA-E), including brain edema or sulcal effusions, and/or amyloid-related imaging abnormalities hemosiderin deposition (ARIA-H), inclduing microhemorrhage and superficial siderosis? ☐ **Yes** ☐ **No**
09. Has the beneficiary had a failure of or inability to tolerate at least one other preferred cholinesterase inhibitor Alzheimer therapy for at least four months? ☐ **Yes** ☐ **No**
09a. Please List: _____
10. Does the provider attest to obtain MRIs prior to the 7th infusion (first dose of 10 mg/kg) and 12th infusion (sixth dose of 10 mg/kg)? ☐ **Yes** ☐ **No**
11. Is the beneficiary hypersensitive to any components of Aduhelm? ☐ **Yes** ☐ **No**
12. Is Aduhelm being prescribed by or in consultation with a neurologist, geriatrician, or geriatric psychiatrist?
☐ **Yes** ☐ **No**

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Signature of Prescriber: _____ Date: _____
(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to **1-800-678-3189**
Pharmacy PA Call Center: **1-866-799-5318**